Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1/20/11
Amount 1875.00

GGNSC Administrative Services, LLC #81143759

I. IDENTIFICATION

Name Golden Living Center ST. Matthews

Address 227 Browns Lane

City/County/Zip Louisville 40207

Telephone number 502-893-2595

Administrator Josh Schindler

Date facility operation began at current address 1968

Date facility began operation under current owner 2006

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JAN 20 2011
OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	125	125
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	(Profit)	Individual
County	Nonprofit	Partnership
City		~~Corporation~~
(Private)		(LLC)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

GGNSC Louisville ST Matthew's LLC
1000 Fianna Way
Fort Smith 72919

(OVER)

12/31

If facility owned or leased by a corporation, complete the following:

Name of corporation GGNSC

Address of corporation 1000 Fianna Way, Fort Smith AR 72919

President or Chairman Larry Deans

Vice President Kevin Roberts, Larry Joseph, John Grabmyer, David Morrell

Secretary Holly Jones

Treasurer Ann Truitt

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
1000 Fianna Way Fort Smith, AR 72919	N/A

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Joanna S. Schuster — Executive Director — 1/10/11

Signature of authorized representative — Title — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

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(10/2002)